Readmission Care Partner sprint

Office hour: Preparing for Attestation

February 17, 2022

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Transforming into a Care Partner Hospital

Today's faculty

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Eastern US Quality Improvement Collaborative (EQIC)
Health Association of New York State (HANYS)

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Healthcare Association of New York State (HANYS)

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This session is for you to network and share!

We want to hear from you!

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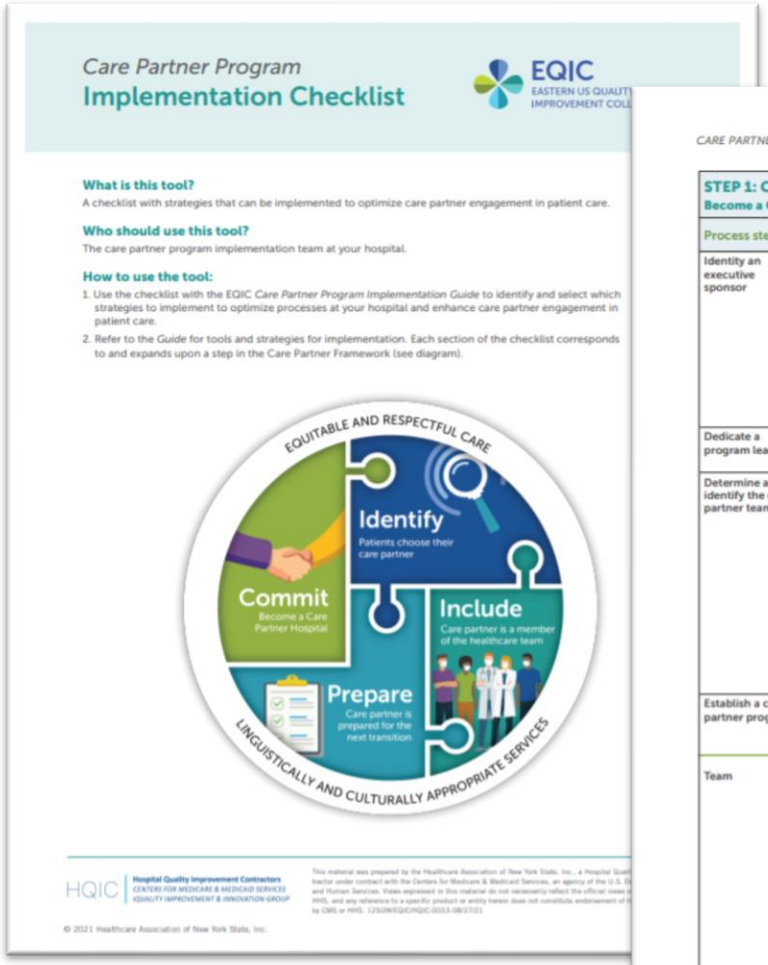
Preparing for attestation: Care Partner Implementation Checklist and Attestation



Care Partner Program
Implementation Checklist

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What is this tool?
A checklist with strategies that can be implemented to optimize care partner engagement in patient care.

Who should use this tool?
The care partner program implementation team at your hospital.

How to use the tool:
1. Use the checklist with the EQIC *Care Partner Program Implementation Guide* to identify and select which strategies to implement to optimize processes at your hospital and enhance care partner engagement in patient care.
2. Refer to the *Guide* for tools and strategies for implementation. Each section of the checklist corresponds to and expands upon a step in the Care Partner Framework (see diagram).

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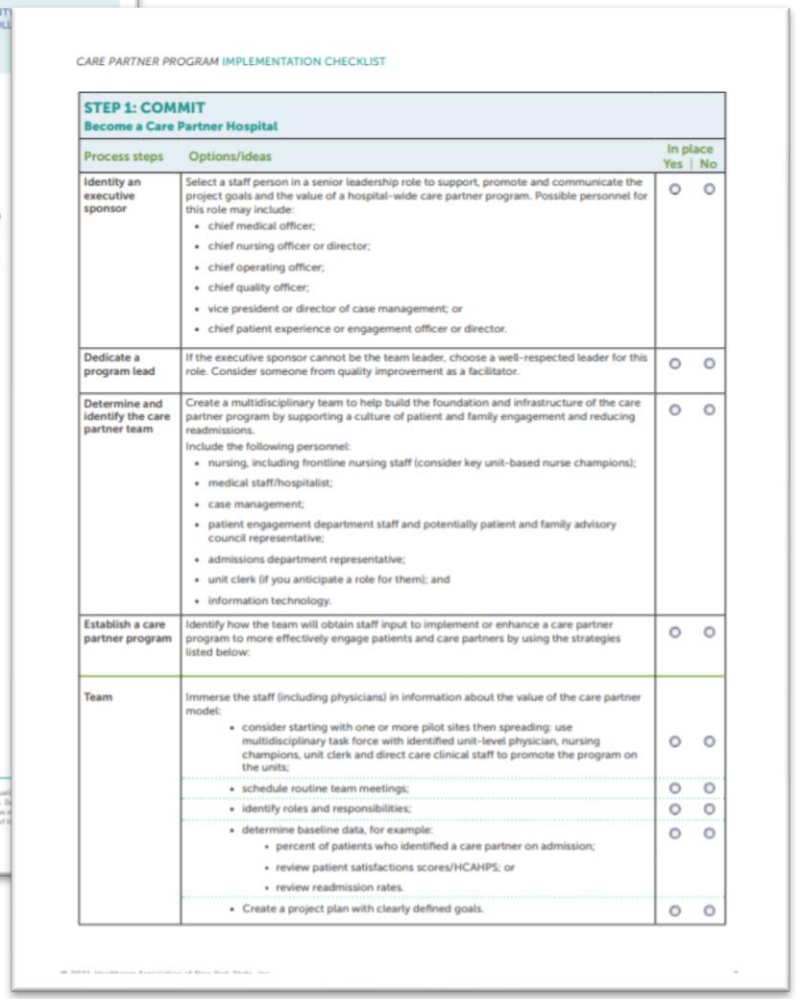

CARE PARTNER PROGRAM IMPLEMENTATION CHECKLIST

STEP 1: COMMIT
Become a Care Partner Hospital

Process steps	Options/ideas	In place Yes	No
Identify an executive sponsor	Select a staff person in a senior leadership role to support, promote and communicate the project goals and the value of a hospital-wide care partner program. Possible personnel for this role may include: • chief medical officer; • chief nursing officer or director; • chief operating officer; • chief quality officer; • vice president or director of case management; or • chief patient experience or engagement officer or director.	○	○
Dedicate a program lead	If the executive sponsor cannot be the team leader, choose a well-respected leader for this role. Consider someone from quality improvement as a facilitator.	○	○
Determine and identify the care partner team	Create a multidisciplinary team to help build the foundation and infrastructure of the care partner program by supporting a culture of patient and family engagement and reducing readmissions. Include the following personnel: • nursing, including frontline nursing staff (consider key unit-based nurse champions); • medical staff/hospitalist; • case management; • patient engagement department staff and potentially patient and family advisory council representative; • admissions department representative; • unit clerk (if you anticipate a role for them); and • information technology.	○	○
Establish a care partner program	Identify how the team will obtain staff input to implement or enhance a care partner program to more effectively engage patients and care partners by using the strategies listed below:	○	○
Team	Immerse the staff (including physicians) in information about the value of the care partner model: • consider starting with one or more pilot sites then spreading; use multidisciplinary task force with identified unit-level physician, nursing champions, unit clerk and direct care clinical staff to promote the program on the units;	○	○
	• schedule routine team meetings;	○	○
	• identify roles and responsibilities;	○	○
	• determine baseline data, for example: • percent of patients who identified a care partner on admission; • review patient satisfactions scores/HCAHPS; or • review readmission rates.	○	○
	• Create a project plan with clearly defined goals.	○	○

Care Partner Program
Attestation

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Implementing the Eastern US Quality Improvement Collaborative's Care Partner Program showcases your organization's significant and ongoing commitment to reducing readmissions by engaging the patient and care partner in treatment to enhance patient care. By adopting a care partner model and implementing or enhancing a care partner program, you are reinforcing your organization's dedication to achieving and maintaining these goals. EQIC has provided support to participating hospitals with educational programs, information on best practices and technical assistance with the implementation of a Care Partner Program.

Signing the Care Partner Program Attestation indicates that your organization has:

- implemented interventions within each step of the EQIC Care Partner framework facilitywide.

In recognition of your implementation of the Care Partner Program, your organization will receive:

- designation as an EQIC Care Partner Hospital, including materials to advertise to your patients and the community that you have achieved this designation.

I attest that

ORGANIZATION NAME

has, to the best of my knowledge, implemented interventions within each step of the EQIC Care Partner framework facilitywide.

DESIGNATED EXECUTIVE NAME | DESIGNATED EXECUTIVE SIGNATURE | DATE

EMAIL | TELEPHONE

PLEASE SUBMIT YOUR COMPLETED attestation form, along with your completed Care Partner Program Implementation Checklist, to your EQIC project manager.

Contact your project manager or Brenda Chapman (bchapman@hanys.org) with any program questions.

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Care Partner Implementation Checklist

- ✓ Review implementation strategies
- ✓ Review and complete all process steps
- ✓ Document reason that process within step was not completed (review with your project manager)
- ✓ Executive signs to attest ***all*** process steps have been completed
- ✓ Forward completed Care Partner Program Attestation and Implementation Checklist to your project manager

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Care Partner Framework

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STEP 1: Commit

- Dedicate a program leader
- Establish a care partner program
- Broadly promote the care partner role
- Continuously evaluate and improve the program

STEP 2: Identify

- Support patient to designate a care partner
- Introduce care partner to the medical team
- Identify a proxy care partner in special circumstances
- Display name and contact information of care partner in highly visible areas
- Provide a visual identifier for care partner to wear in the hospital

STEP 3: Include

- Orient the care partner to the unit environment and routine
- Invite care partner to daily patient rounds and bedside huddles
- Involve care partner in discussions about the patient's care plan
- Empower care partner to perform simple patient care activities

STEP 4: Prepare

- Assess care partner's education needs
- Educate care partner on essential care activities at home
- Allow care partner to demonstrate understanding using teach-back
- Integrate care partner into discharge planning
- Discuss and plan for post-discharge medical care with care partner

Commit

- Who is the executive sponsor?
  - CMO, CQO, CPX, CNO,
- Have you identified unit-based champions?
- Tell us what your team looks like
- What challenges have you encountered?

STEP 1: Commit

- Dedicate a program leader
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Commit

Polling Question: Which of the below interventions has your team implemented?
(Select multiple)

- Input of your PFAC
- Gather staff input
- Identify data metrics to collect and monitor
- EQIC tools have been adapted, adopted
- Create unique hospital tools
- Educate physicians and staff
- Promote the program

STEP 1: Commit

- Dedicate a program leader
- Establish a care partner program
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Identify

- Who is the first person in your organization to ask the patient to identify a care partner?
- Did you provide a script for asking the patient to identify?
- Who asks next if the patient was unable to identify when first asked?
- Has your team identified care partner proxy(s) or a process if a patient is unable to identify a care partner?
- How is the care partner information shared with the healthcare team and made visible?
- Is the care partner oriented to the unit and schedul

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Include

- Do you discuss goals and care plan with care partner?
- Do you gather “what matters” from the patient and care partner?
- Does the care partner get a daily update?
- Do the patient and care partner receive the My Care Transitions Brochure or similar communication tool?
- Is there documentation in EHR for the care partner’s participation in goal setting and understanding of daily goals?

STEP 3: Include

- Orient the care partner to the unit environment and routine
- Invite care partner to daily patient rounds and bedside huddles
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- Empower care partner to perform simple patient care activities

Essence of include

- Care partner orientation: to the role, to the unit, to the team
- Establish the care partner's preferred communication method
- Establish a welcoming and compassionate culture from the start
- Provide a tour of the unit
- Review unit-specific routines and schedules
- Educate the patient and care partner on how to use the whiteboard or other method of communication tool for sharing information
- Issue invitation to rounds/huddles
- Care partners are given information on how to contact the medical team and what to expect for daily updates

Care partner communication tools

My Care Transition Plan

Patients with caregivers and/or care partners are asked to complete this form, which lists their concerns on care needs at home. Hospital staff will work with you to address concerns on the list.

PATIENT NAME: _____

PHONE NUMBER(S): _____

CARE PARTNER: _____

PHONE NUMBER(S): _____

FOLLOW-UP APPOINTMENT: _____

MY PHARMACY: _____

CASE MANAGER: _____

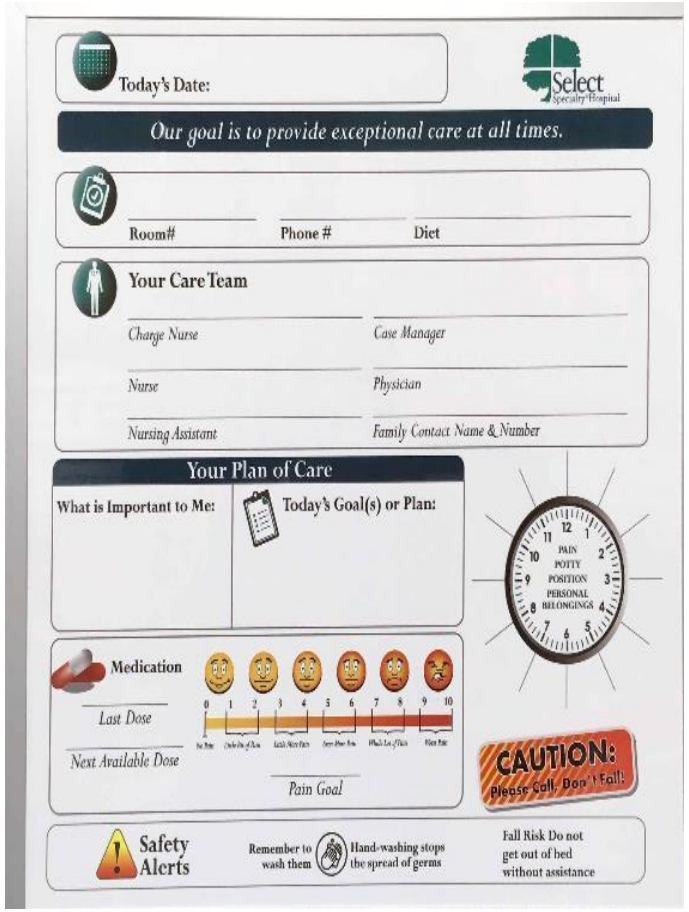
Care Partners are SMART* and AWARE

S Signs and symptoms to look for and who to call
M Medication changes or special instructions
A Appointments
R Results on which to follow up
T Talk with me about my concerns

A Available
W Writing notes
A Alert me about changes
R Receive information
E Educate me about my home care needs

*"SMART Discharge Protocol." The Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx (accessed August 20, 2021).

	I AM CONCERNED ABOUT...	YES	NO	COMMENTS
Follow-up Medical Care	Having all the information I need when I leave the hospital			
	Follow-up care after leaving the hospital			
	Scheduling follow-up appointments and/or tests			
	Who to call with questions or concerns			
	How I will get to my follow-up appointment			
	Whether I will need home nursing, therapists, nutritionists			
	The type of medical equipment I will need (e.g., walker, crutches, insulin pump, oxygen)			
	Managing my wound care			
	Paying for the care I need			
Medications	Which medications I should take at home			
	When to take my medications			
	Taking my medications as prescribed (e.g., swallowing)			
	Understanding the side effects of my medications			
	Paying for my medications			
	Getting my medications from the pharmacy			
Activities of Daily Living	Getting help with personal care (e.g., bathing, dressing)			
	Cooking meals			
	Getting help with grocery shopping			
	Using medical equipment, changing a bandage or giving an injection			
Care Partner	How my care partner will help me when I am at home			
	How my care partner will manage my illness			
	Losing contact with friends and family and feeling isolated or left behind			
Culture	Whether I will be able to keep my core beliefs and values despite my illness			



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Prepare

- Describe how you assess the needs of the care partner.
  - What is included in your risk assessment tool?

- When do you plan and discuss discharge dates with physician, staff, patient and care partner?

- When do you notify the patient and care partner of the discharge date?

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Assess care partner needs and understanding

- Use the EQIC Mitigating Risk Factors for Readmission Tool or another tool to identify risks for readmission, including health equity issues that need to be addressed.

- Plan and discuss discharge date with physician staff upon admission. Notify the patient and care partner of planned discharge date 24 to 48 hours in advance.

Educate the care partner on essential care activities at home

- Describe how you ensure patient and care partner understanding of the discharge plan/transition.
- What education do you provide when preparing for care transitions?

Is the care partner part of the discharge planning?

- How does the patient communicate concerns and questions to the medical team?

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Polling question

Do you include the care partner in post-discharge phone call?

- YES
- NO

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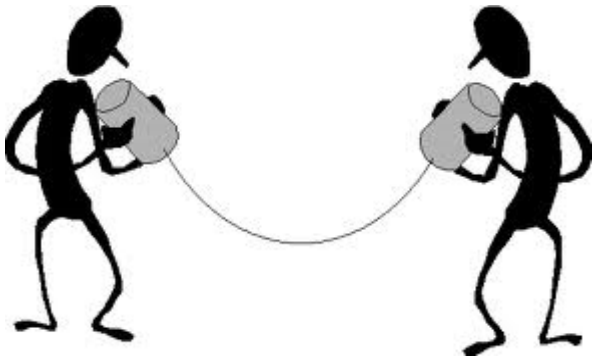
Post-discharge follow-up phone call

- ✓ Confirm patient and care partner phone numbers
- ✓ Who sets up the follow-up appointments?
- ✓ Medication reconciliation process
- ✓ Share information and concerns



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Framework implemented

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Eligibility for designation as an EQIC Care Partner Hospital

Care Partner Program
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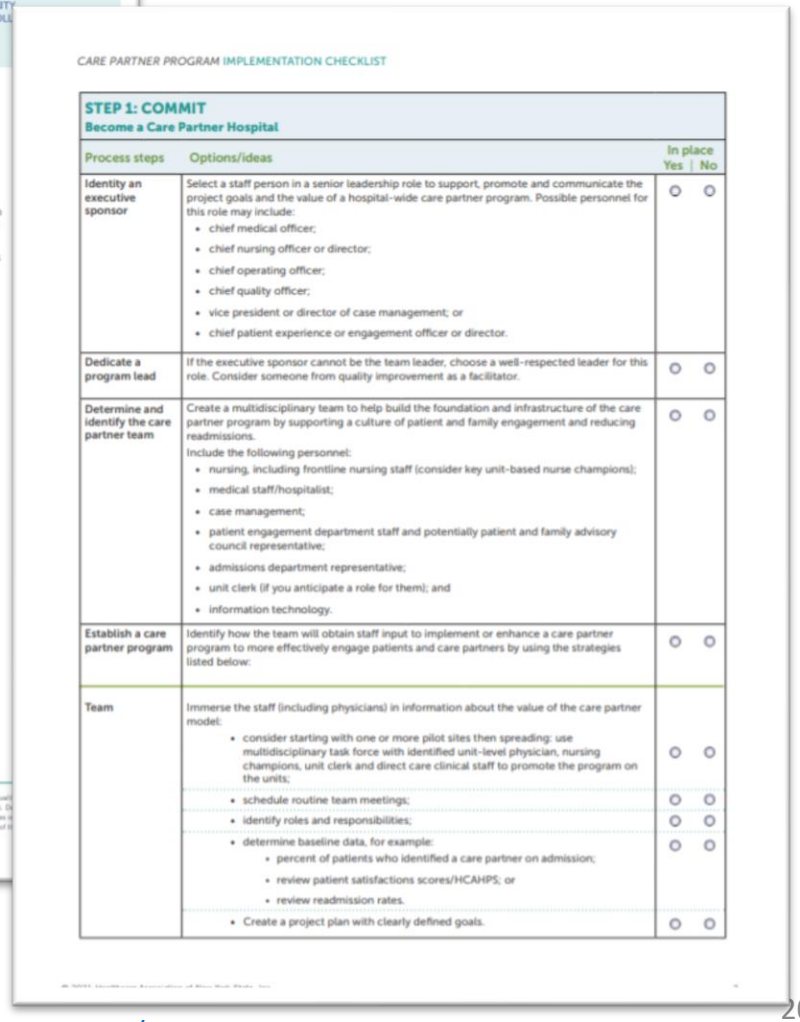

CARE PARTNER PROGRAM IMPLEMENTATION CHECKLIST

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	• determine baseline data, for example:
	  • percent of patients who identified a care partner on admission;
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	  • review readmission rates.
		○	○

	• Create a project plan with clearly defined goals.	○	○

https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources/

Questions?

Thank you for your commitment to becoming a Care Partner Hospital!

Contact your EQIC project manager with any questions.

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Next steps

- March 17 – Transitions of care
- April 21 – Celebration and success stories

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Thank you.

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